

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN2601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/05/2011
NAME OF PROVIDER OR SUPPLIER  SOUTHERN TENN MEDICAL CENTER SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 628 HOSPITAL ROAD WINCHESTER, TN 37398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{N 002}	1200-8-6 No Deficiencies  An annual licensure survey was conducted at Southern Tennessee Medical Center Skilled Nursing Facility, no deficiencies were cited in relation under 1200-8-6, Standards for Nursing Homes.	{N 002}			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6825

VN2012

TITLE

(X6) DATE

4-12-11

If continuation sheet 1 of 1